ANNEX I
Background and Current Efforts

Background

Ukraine has the most severe HIV/AIDS epidemic in Eastern Europe & Central Asia. At the end of 2005 an estimated 377,600 Ukrainians were living with HIV and by 2014, 3.5% of the Ukraine's adult population, 820,000 people, may be living with HIV. If not controlled, it is projected that AIDS will account for 35% of male deaths and 65% of female deaths in the 15-49 age group by 2014. More than 8,700 people have died of AIDS since the beginning of the epidemic, which is projected to grow to 300,000 cumulative deaths by 2014 if treatment is not expanded.

At the end of June 2006, 67,974 people were diagnosed as living with HIV and were under clinical observation in the network of 27 regional AIDS Centers throughout the country. The epidemic is rapidly spreading beyond the ten regions in southern and eastern Ukraine where over two-thirds of all HIV cases have been reported to date. Sharp increases in reported cases are now also occurring, primarily among vulnerable populations of injection drug-users (IDUs), female sex workers (FSWs) and patients with sexually transmitted infections, in central and northern regions of Ukraine – regions historically less affected by the epidemic. It is believed that less than one person in six living with HIV has been tested and is aware that he or she is infected.

Despite today's estimated adult prevalence of 1.46%, the epidemic in Ukraine is still classified as concentrated. Even with an increasing proportion of infections related to heterosexual and vertical transmission, it is clear that the HIV epidemic in Ukraine is being fueled by unsafe injection drug use with the vast majority of cases either directly or indirectly related to this risk. Injection drug use remains the most frequently identified path of infection representing 45.3% of newly reported cases in 2006 and 60% of all cases reported to date. The social and economic marginalization of individuals at risk for injection drug use exacerbates the risk of transmission within and from these drug user and sexual networks, providing opportunities for transmission to lower-risk individuals.

Of the growing proportion of cases of heterosexual transmission, 35.4% of new cases in 2006, an estimated 50%-60% are occurring among the partners of IDUs and of other high risk groups including female partners of MSM and partners of FSW clients. Female sex workers, especially those who also inject drugs (24% of FSWs), are the second high risk group after IDUs. Vertical transmission from mother to child is responsible for 16.4% of new infections and 16% of infants born to HIV-positive mothers are themselves infected. Eleven percent (11%) of them are abandoned at birth. The younger age-groups bear the brunt of the epidemic. Two-thirds (66.2%) of newly reported cases are among individuals aged 20-39 and 15.6% occur in those between 15 and 24 years. Among the estimated 115,000 street children 20% - 69% are thought to be HIV-positive. An exceedingly high level of stigma and discrimination is one of the key factors limiting access to prevention, voluntary testing and counseling (VCT), treatment and other health and social services for at-risk or HIV-infected individuals.

The situation is worsened by growing rates of active tuberculosis (TB), including multi-drug resistant (MDR-TB) and extensively resistant TB (XDR-TB) and HIV/TB co-infection. It is estimated that 16% of TB cases are HIV-positive and that 30% of HIV patients have active TB. TB accounted for 60% of deaths in HIV-positive people in Ukraine in 2005. Highly vertical and separate diagnostic and treatment systems for TB and HIV deter early detection and fragment care.

Significant progress in responding to HIV/AIDS has been made, especially since the reinstatement of the GF Round 1 grant in March 2004. The close partnership of national and international non-governmental organizations, national and local AIDS centers, and clinical facilities supported by the GF, has resulted in a sharp increase in access to life-saving anti-retroviral medicines, with a total of 4,680 people receiving treatment as of mid-2006 compared to 255 in April, 2004. The Government of Ukraine (GOU) reports that access to PMTCT among HIV-positive pregnant women, 2,203 of whom received some ART in 2006, is now estimated at 86%, leading to a sharp drop in Ukraine's rate of mother-to-child transmission of HIV from 40% in 2000 to between 7.7% (GOU figure) and16% (recent study)in 2006.

There is very strong collaboration on HIV/AIDS within the donor community. The USG played a key role in the re-instatement of the first GF grant, the preparation and subsequent discussions on the latest GF grant and the provisional re-instatement of the WB loan for HIV/AIDS and TB. The GOU has stated its commitment to meet ambitious HIV/AIDS prevention and treatment objectives outlined in a "National Road Map on Scaling-up Towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Ukraine by 2010", which forms the framework for the GF Round 6 proposal. This strategic proposal jointly developed by GOU and civil society partners aims to achieve the Road Map's Universal Access goals, prioritizing prevention interventions for the first time and continuing and expanding integrated treatment, care and support especially for the most vulnerable PLWH. The GF Round 6 proposal builds on the civil society and national and provincial (oblast) coordinating mechanisms developed with USG-support. Further development of strong collaborative networks between NGOs and local government to provide a continuum of care to PLWH is one of 15 Strategic Service Delivery Areas in the GF proposal. Small cities and rural areas are for the first time an expressly included target.

Ukraine follows a "Three-Ones" process with one national HIV/AIDS action plan, one national HIV/AIDS coordinating authority and one national HIV/AIDS M&E system. The National Coordination Council (NCC) for the Prevention of HIV/AIDS was established in 2005 by Presidential degree. The current National AIDS Program provides a strong basis for inter-sectoral cooperation among government agencies and between the government, non-government and international organizations. The 17-member NCC includes representatives from government ministries, the parliament, NGOs, the private sector and international donors. The national strategy underscores the inclusion of target populations, particularly PLWHA, in the design, implementation, monitoring and evaluation of the National AIDS Program. All partners are committed to strengthening

the NCC to ensure transparent decision-making and accountability to intended beneficiaries. UNAIDS has the leadership role in working with the national government on the collection and analysis of strategic information. All USG partners contribute to the collection of data for the national M&E system including relevant PEPFAR indicators.

The HIV response in Ukraine is handicapped by the legacies of Soviet rule: weak political leadership, antiquated policies, high levels of social stigma, discriminatory policies, corruption, an under-developed civil society and limited government resources for achieving the overall goals outlined in the national Road Map handicap the response in Ukraine. Within the health care system key challenges include the legacy of Soviet-style diagnostic and treatment modalities and high levels of stigma and discrimination. Complete voluntary testing and counseling (VCT) is restricted to 27 government AIDS centers, limiting access to the many reluctant to reveal their status in these facilities. Response to the needs of IDUs is constrained by the restricted use of Methadone and limited availability of integrated HIV, TB and drug dependence prevention, testing, counseling and care. Children born to HIV-positive mothers are not diagnosed until 18 months of age leading to child abandonment , restricted access to social services and a host of other problems for these children and their families. HIV-positive battered and homeless women are barred from shelters.

Mismanagement of resources throughout both government and civil society organizations continue to threaten the long term sustainability and viability of donor supported HIV/AIDS prevention, treatment and support activities. Both corruption and lack of management expertise play a role in the misallocation of government and civil society resources. Misallocation of government funds to support the purchase of drugs and supplies of questionable value continues to be sustained by private interests and limits GOU allocations to proven and internationally recognized interventions. For example, the GOU now provides ARVs to only about 17% of HIV patients currently under treatment. However, under new Ministry of Health leadership, the GOU is progressively increasing its allocations for ARV drugs.

Current Efforts

In 2002, the United States Government (USG) was among the first to respond to emerging evidence of a growing HIV/AIDS epidemic in Ukraine with a three-pronged strategy directed at strengthening national policy, delivering care and prevention to affected populations and increasing in-country service delivery capacity. For the past four years, as the largest HIV/AIDS bilateral donor, the USG has been in the forefront through a strategically focused program combining advocacy, service delivery capacity building, policy development, civil society organizational strengthening, networking with local champions, and fostering effective collaboration between civil society and government and among donors. This strong foundation has not only been instrumental in fostering the opportunities represented by the GF and WB funding, but provides the structure on which future progress will be built.

Ukraine's HIV/AIDS epidemic is worsened by one of the most serious Tuberculosis epidemics in Europe. As the principal donor of TB-DOTS programs in Ukraine, USAID, through its partners PATH, WHO and HPI (Constella Futures Group), has over the past few years successfully introduced DOTS to six of the most affected oblasts/provinces: Ukraine Donetsk, Kharkiv, Dnipropetrovs'k, Zaporizha, Kherson and the Autonomous Republic of Crimea.. These efforts have considerably improved diagnosis and treatment of TB and are expected to reach 40% of Ukraine's population by the end of 2007. DOTS plus services are being rolled out in Donetsk by WHO with funding from a local philanthropic organization. Over the next four years USAID will continue to support the expansion of DOTS based diagnosis and treatment, including DOTS plus including HIV-TB co-infection. DOTS-based services are expected to reach 65% of the population and HIV-TB co-infection services 50% of the population by 2011.

The number of HIV-positive women has increased over the past five years-from 997 in 2000 to 3997 in 2005, an average annual increase of 20%. Since 2000, GOU and international donors have been developing and rolling out a national PMTCT program. Although over 85% of HIV-positive pregnant women are covered by the PMTCT program, quality of services must be improved to get the rate of MTCT below 5% from current rates of up to 16%. Current USAID activities, implemented in nine oblasts, including eight with the highest HIV prevalence rates, are aimed at integrating HIV counseling and testing and other PMTCT interventions into mainstream reproductive, maternal and child health services. USAID will continue to support expansion of high quality PMTCT services that meet international standards to meet the needs of over 90% of HIV-positive pregnant women over the next four years.

In October 2004, the USG's Displaced Children and Orphans Fund supported an initiative by Holt International to build a continuum of family-based care services, including services in support of family preservation, adoption and temporary family-based care, such as foster care and family type homes for Ukrainian orphans. This program currently works in five localities in three oblasts: Dnipropetrovs'k (Dnipropetrovs'k city and Novomoskovsky rayon), Kyiv (Brovarskyi rayon and Cherkassy (Uman city and Umanski rayon). Since July 2005 the 24-month USAID-funded MAMA+ project, implemented by Doctors of the World, in collaboration with the All Ukrainian Network of People Living with HIV/AIDS has been building local capacity and commitment to keep children born to HIV-positive mothers within the biological family environment in: Kyiv city, Donetsk city and Simferopol, Feodosa and Kerch cities in the Autonomous Republic of Crimea. The project employs a multi-disciplinary case management methodology focused on direct provision of social, medical and psychological support to HIV-positive mothers, their children and families. USAID will continue and expand efforts to reduce abandonment and increase access to family care for OVC and strengthen access of HIV-positive children to HIV treatment, care and support services.

The USG remains the primary financial supporter of the systems that facilitate addressing the policy needs of national and local programs. National, provincial (oblast), municipal and coordination of policy development and implementation has been a focus of the past

four years. This has included the establishment of a National HIV/AIDS Coordination Council, supporting the Council's policy work through sector specific working groups, establishment and support of similar bodies at the oblast and municipal levels, and site level coordination networks.

Results have included growing support for urgently-needed HIV/AIDS policy changes, greatly enhanced civil society participation in policy-making, advocacy and program implementation and rapidly expanded HIV/AIDS interventions, especially at provincial (oblast) levels. The Government of Ukraine (GOU) has now identified the HIV/AIDS epidemic as a public health priority. A Presidential degree established the National Coordination Council (NCC) for the Prevention of HIV/AIDS in 2005. More recently the GOU agreed to integrate Tuberculosis under the aegis of the NCC. National level results have also included the successful application for GF Round 6 funds.

National HIV prevention and treatment policies are increasingly in line with international standards. Policy advances have included the recent approval of methadone substitution therapy and approval of the first national PMTCT program. Key challenges remain: the limited allocation of government resources; the need for specific protocols for HIV/TB co-infection diagnosis and treatment, PMTCT, substitution therapy and others; the current limitation on private sector, including civil society, implementation of the full package of VCT and treatment of multiply-affected individuals (e.g. IDUs with HIV and/or Tuberculosis); the barriers to the introduction of rapid testing; and legal, regulatory and human rights issues related to restrictions on access to social services.

With the goal of leveraging new GF Round 6 resources and assuring their effective and efficient use, the USG continues to make service capacity building, including strengthening technical and administrative/management capacity in national, regional and municipal public institutions and civil society organizations, a high priority. Under the leadership of UNAIDS, USG programs contribute actively to the strengthening of the national HIV-related monitoring and evaluation (M&E) efforts.

Over the past four years the role of civil society in the planning, implementation and monitoring of HIV/AIDS interventions has increased dramatically. NGOs and other civil society organizations actively participate in national and regional level policy and strategy councils and work closely with government services to implement programs. A unique collaborative relationship has evolved between civil society and government service providers at many sites to provide a continuum of preventive, treatment and follow-up care to PLWHA. These "coordinated care networks" will be expanded under Global Fund (GF) Round 6 funding to cover an additional 90 communities.

USAID, through its partners, works with well over 100 NGOs and civil society groups. Weak institutional capacity among nascent civil society groups in smaller communities limits access to services of the more marginalized and highest risk groups. The majority have been created in the last 5 years, and, though many provide valuable services, most are organizationally immature. Only two or three are currently capable of directly receiving and managing donor funds, though many have received small grants from a

variety of national and international donors. Two have been accepted as Principal Recipients of the GF Round 6 grant.

The new GF program aims to rapidly and significantly scale up service provision to a wide variety of high risk populations, including in small towns and communities, by mobilizing both NGO and public sector service providers, in part through the provision of small grants. Strengthening technical and management/administrative capacity of these key civil society organizations, as well as relevant local public sector services, will be vital to the achievement of the ambitious goals elaborated in the GF proposal.